

Seven Hills Women's Health Centers

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Facility/Provider to Release Medical Records: _____

Address of Facility/Provider to Release Medical Records: _____

I hereby authorize the above named Facility/Provider to release medical records in its possession, including information regarding my medical condition and treatments I have received to Seven Hills Women's Health Centers, Seven Hills Physician _____ at the following locations:

7495 State Road, Ste 300
Cincinnati, Oh 45255
513 231-3447
fax 513 231-3761

2859 Boudinot Ave, Ste 101
Cincinnati, Oh 45238
513 481-5100
fax 513 481-3880

6350 Glenway Ave, Ste 205
Cincinnati, Oh 45211
513 922-6666
fax 513 922-1812

7495 State Road, Ste 325
Cincinnati, Oh 45255
513 233-2000
fax 513 624-2684

10506 Montgomery Rd, Ste 201
Cincinnati, Oh 45242
513 791-6268
fax 513 791-2138

5049 Crookshank Rd, Ste 102
Cincinnati, Oh 45238
513 922-0009
fax 513 922-2931

9312 Winton Road
Cincinnati, Oh 45231
513 931-3530
fax 513 931-2481

10495 Montgomery Rd, Ste 29
Cincinnati, Oh 45242
513 984-8850
fax 513 984-3784

1010 Cereal Avenue, Ste 207
Hamilton, OH 45013
513 867-4555
fax 513 867-4556

_____ Release medical records for date(s) of service ____/____/____ to ____/____/____

_____ Release these specific diagnostic test/operative records: _____

_____ Release entire medical record

I understand the information to be released may include information regarding the following conditions: sexually transmitted diseases, HIV testing and status, drug or alcohol abuse and psychiatric conditions.

Purpose or reason for the use and/or disclosure of the information requested:

Expiration date of this medical release: ____/____/____ or specify number of days _____.

Signature of Patient

Date

Authorization is not valid without a signature and date by the patient. The request must be filled out completely. Refusal to sign an authorization to have records transferred to Seven Hills will not result in an interruption of treatment.